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Citation for final published version:

Rotarou, Elena S and Sakellariou, Dikaïos ORCID: <https://orcid.org/0000-0002-2668-2834> 2017. Neoliberal reforms in health systems and the construction of long-lasting inequalities in health care: A case study from Chile. Health Policy 121 (5) , pp. 495-503. 10.1016/j.healthpol.2017.03.005 file

Publishers page: <http://dx.doi.org/10.1016/j.healthpol.2017.03.005>
<<http://dx.doi.org/10.1016/j.healthpol.2017.03.005>>

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Title page

Title: Neoliberal reforms in health systems and the construction of long-lasting inequalities in health care: A case study from Chile

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Acknowledgements

Elena S. Rotarou's work was supported by the Conicyt-Fondecyt, Postdoctorate Programme (project number 3140481).

Conflict of Interest

The authors report no conflict of interest.

Neoliberal reforms in health systems and the construction of long-lasting inequalities in health care: A case study from Chile

Abstract

The aim of this article is to discuss how neoliberal policies implemented in the Chilean health system during the Pinochet regime have a lingering effect on equal access to health care today. The two-tier health system – public and private – that was introduced in the early 1980s as a means to improve efficiency and lower health-related costs, has led instead to inequality of access and dehumanisation of health care. Health has changed from being a right to being a marketable need, thus creating a structural disadvantage for several parts of the population – particularly the poor, the elderly, and women – who cannot afford the better-quality services and timely attention of private health providers, and thus, are not adequately protected against health risks. Despite the recent health reforms that aim at improving equity in health care access and financing, we argue that the Chilean health system is still biased against the poorer segments of the population, while it favours the more affluent groups that can afford private health care.

Keywords: neoliberalism, Chile, health system, health care, public and private health care, inequalities

Highlights

- Neoliberalism produces negative, long-lasting effects on health systems.
- The Chilean health care system disadvantages parts of the population.
- The marketisation of the Chilean health care system has led to pro-rich bias.

Introduction

Health care is considered as one of the main pillars of social policy, together with education and social welfare (Brooks 1998). Health care policy involves governments' decisions regarding cost, quality, delivery, accessibility, and evaluation of programmes and initiatives aimed at ensuring the well-being of the population, and especially of some groups that might be marginalised, including children, the elderly, the poor, aboriginals, and women (McGregor 2001). Neoliberal health care reforms – that are often presented as restructuring of ineffective and costly health care systems – imply different aims, targets, and mechanisms that aim at satisfying the goals of a free-market system.

The aim of this article is to discuss the material effects of neoliberalism on health care, using Chile as a case study, and highlight the ways neoliberalism can create long-lasting effects on health care systems. There is a wealth of analyses (e.g. Ayo 2012) on the link between neoliberalism and the creation of layers of exclusion and disadvantage through an increasing emphasis on health as choice, that is, a matter of personal responsibility. We argue that neoliberalism – with its focus on free-markets, individualism, liberalisation, and deregulation – does not include in its agenda the welfare of people, communities, and societies. Through a process of marketisation, health is no longer regarded a human right but becomes a need / product that people need to manage privately. Furthermore, other effects of neoliberalism, such as the informalisation of the job market, can also impact on people's access to health care, predominantly affecting the poorer segments of the population who are in precarious employment.

Chile is viewed as the first country where neoliberal economic reforms were applied in 1975, under the military dictatorship of Augusto Pinochet. While the

neoliberal ‘shock therapy’ and structural adjustment programmes that were adopted by many countries led to instability and poor growth, this was not the case with Chile. Although initially its economy did not improve, it did manage to eventually escape the failure of unregulated free markets and free trade policies. As a result, from neoliberal advocates to strong critics of neoliberalism, Chile is viewed as an ‘economic miracle’ and portrayed as a great exception among Latin American countries that have suffered from economic stagnation, corruption, or instability (Barro 2000; Friedman 1982; Stiglitz 2002). Currently, Chile is a high-income country – according to the World Bank – and, since 2010, the first South American country member of the Organisation of Economic Cooperation and Development (OECD 2010). Furthermore, Chile has universal health coverage: all citizens are entitled to access to health services in a non-discriminatory and dignified manner, and, therefore, all Chileans have health insurance, whether public or private (Law 20584, Ministry of Health 2012).

Nevertheless, despite the numerous accolades the country has received regarding its impressive economic growth, the neoliberal policies adopted in Chile have had a long-lasting negative impact on welfare provision, especially concerning the health and education systems (Matear 2007; Missoni and Solimano 2010; Rojas 2011). Although great improvements have been made during the last few decades, the country still suffers from high income inequality, unequal educational opportunities, and inequitable health care access (Rotarou and Sakellariou 2017; Unger et al. 2008). We argue that the health care system remains a topos of structural disadvantage, a space that is neither universally nor equitably accessible; in Chile, neoliberal policies have led to unequal access and dehumanisation of health care.

In the sections that follow, Chile is taken as a clear example of a country that was forced to apply neoliberal measures to its economy, spearheaded by a dictatorial

regime and international actors. In the first part of the article, we present an overview of neoliberalism and the impact of neoliberalism on health systems in general. We then focus on Chile and describe the introduction of neoliberal policies in health care in the country, and outline the current situation, before presenting the concluding remarks.

Background: Neoliberalism

Neoliberalism is the term often used to describe the current global economic regime. Neoliberal economic theory promotes ‘free-market’ or ‘laissez-faire’ economics; as a political ideology, it emphasises that the role of national governments, local authorities, and institutions is to provide regulatory frameworks that enable global markets to function successfully (Scholte 2005). Private institutions are deemed as more capable and effective than governments at delivering social services, including health and education. This has resulted in the slashing of government welfare spending in many parts of the world, a fact that has often led to an increase in poverty and inequality rates. Neoliberalism, therefore, rests on the “...*beliefs in the efficacy of the free market and the adoption of policies that prioritise deregulation, foreign debt reduction, privatisation of the public sector...and a (new) orthodoxy of individual responsibility and the “emergency” safety net - thus replacing collective provision through a more residualist welfare state*” (Hancock 1999: 5).

There are many definitions of neoliberalism and what it stands for: it has been defined as “...*a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets and free trade*” (Harvey 2005: 2). Other definitions refer to neoliberalism as “...*the ideology and practice of the dominant classes of the developed*

and developing worlds alike” (Navarro 2007: 53). Neoliberal philosophy has been used in an attempt to legitimise “...*the minimalisation of the State in terms of its restructuring through corporatisation and privatisation*” (Horton 2007: 1), an exact opposite view of Keynesian welfarism that envisioned the state as the provider of goods and services in order to ensure the social well-being of the population (Turner 2008).

Liberalism stems from the 1776 work of Adam Smith, ‘The wealth of nations’, where he advocated for a minimal role of the government in the economy so that trade could thrive. While this liberal view of economics predominated for the following one hundred and fifty years, it was replaced in the 1930s by Keynesian economics, which promoted a mixed economy with an emphasis on the private sector but with an interventionist role for the government, especially during recessions (Evans and Sewell 2013). While Keynesian economics provided the standard economic model for developed nations since the later part of the Great Depression, due to the 1973 oil crisis and the economic problems of the 1970s, they were replaced by a more ‘monetarist’ approach. At this point, neoliberal ideology emerged in the economic and political debate, with the introduction of neoliberal economic theories by Friedrich Hayek and Milton Friedman, and the spread of neoliberalism as an international ideology through the election of Margaret Thatcher in the UK and Ronald Reagan in the US (Navarro 2007). By the 1990s, communist governments had fallen. Countries that had previously relied on state interventions and welfare provision limited their interventionist role; instead, they proceeded to lifting capital controls, massive and unregulated privatisation of state enterprises, and limiting social welfare, under the ‘guidance’ of international institutions, such as the International Monetary Fund (IMF) and the World Bank.

In the late 1980s and early 1990s, these institutions introduced the so-called ‘Washington Consensus’ – a set of ten economic policy prescriptions for developing countries under crisis. Through these economic prescriptions, and the implementation of ‘shock therapy’, the IMF and the World Bank imposed their own economic solutions that opened the way to the neoliberal regime of the world economy. However, despite the confidence in neoliberal policies to invigorate the economy, this did not happen. In the 1990s, the ‘Washington Consensus’ had very negative results around the world and was being criticised; there was no indication that neoliberal policies had indeed created economic growth (Maddison 2008). According to Evans and Sewell (2013), “...neoliberalism has actually been more successful as a means of shifting the balance of class political power than as an instrument for reinvigorating capitalist growth.” (p. 21).

In general, while it is important to bear in mind that a number of forces – such as demographic challenges, institutional factors, globalisation, pre-existing macroeconomic conditions, and climate change – are also at play, neoliberalism has been pinpointed as the main culprit behind a series of socioeconomic harms. Such negative impacts include increase in socioeconomic inequality and poverty, and reduction in social security. The increased competitiveness and insecurity in the market have also encouraged greater violence, criminality and family breakdown. Neoliberal labour policies have often worsened working conditions through reduction of job guarantees, union protection and other labour rights (Scholte 2005).

Neoliberalism and its impact on the health system

Before the mid-1970s, the concepts used for the reorganisation of health systems envisioned health as a public good and responsibility of states, in agreement with the

concepts of Keynesian welfarism. However, due to global recession and the domination of finance capital in the world economic system, the role of the state was redefined, since the state itself was viewed as inefficient and the cause of the crisis (Iriart, Merhy and Waitzkin 2000). As a result, in the late 1980s and 1990s, Latin American countries were forced to accept the policies promoted by multilateral lending organisations (World Bank, Inter-American Development Bank, IMF) in order to access finance loans. The structural adjustment plans extended to the health sector, as an area that needed restructuring.

Armada, Muntaner and Navarro (2001) investigated the letters of intent between the IMF and each of the involved Latin American countries and noted striking similarities between them: they all incorporated health and social security reforms, promoted the development of ‘basic benefit packages’, targeted basic care at the poorest, and stimulated the increase of private sector involvement in health service provision and health insurance. The growing number of international conglomerates and private health insurance organisations, together with the reduction of governments’ role in the provision of health care services, has had serious, negative impacts on the quality, accountability, cost, access, and equity of health systems. Such institutions, with their focus on increasing profits, and not on providing affordable and good-quality health care, have led to the deterioration of public health systems, increase in urban-rural divide, as well as increase in inequality of access to health care services (Chapman 2014).

Thus, the elaboration of neoliberal regulations in the area of health and the deterioration of the welfare state led to the loss of the notion that health was a universal right. Instead, the main principle of neoliberal health care reform is “...*setting health care up as a private good for sale rather than a public good paid for with tax dollars*”

(McGregor 2001:84). The phenomenon of the ‘health consumer’ reveals the interest of neoliberalism in the acquisition of goods at the expense of society’s well-being. This term also fails to underline the inequalities between various social groups, because patients – unlike consumers – do not always have much power in making decisions regarding health care (Horton 2007). The neoliberal rhetoric in the health care system is not merely guided by general health economics principles, such as spending cuts, deficit cutting, downsizing, and competitiveness, but places them at the core of the health system (McGregor 2001).

While it is argued that a well-functioning health system aims at: 1) improving the health of individuals, families, and communities; 2) defending the population against threats to its health; 3) protecting individuals against the financial costs of bad health; 4) providing equitable access to care that has people at its centre; and 5) enabling people to participate in decisions that affect their health and health system (World Health Organisation 2010), neoliberalism does not share the same goals. It can be argued that neoliberal practices in the field of health, especially with regards to points three and four, go exactly in the opposite direction.

Neoliberal policies in Chile

By 1970, social development in Chile – including level of education, national health system, school meals programmes, and unionised workers – was among the highest in Latin America (CEME 2010). Examples of the efforts to expand coverage of the different areas of social welfare include the introduction of the National Health Service (SNS) in 1952, the National Board of Scholarships and Aid (JUNAEB) in 1964, and the creation of Housing and Urban Development in 1965. Thus, between 1940 and 1970, Chileans were able to access better health and welfare assistance, and better

education opportunities and housing plans, all accompanied by a significant decline in infant mortality. Nevertheless, due to high population growth, the increase in rural-urban migration, and the serious economic difficulties of the period – especially regarding inflation and insufficiency of government revenues – a significant part of the population became excluded from state benefits (Biblioteca Nacional de Chile n.d.). The situation worsened with the 1973 coup by Augusto Pinochet that toppled the elected government of socialist President Salvador Allende.

This was the beginning of the introduction and application of neoliberal policies into the Chilean economy and society, a fact that caused radical changes in the orientation of social policies and de facto ended the welfare state (Biblioteca Nacional de Chile n.d.). These policies extended to many areas, including the health system, pension system, education, cleaning services, and several of the state industries (CEME 2010; Tomic, Trumper and Dattwyler 2006).

In order to achieve these reforms, Pinochet adopted the free-market economic policies advocated by Milton Friedman and the ‘Chicago boys’ (a group of mostly male Chilean economists who were trained during the 1970s at the University of Chicago by M. Friedman and A. Harberger, and who implemented free-market neoliberal policies upon their return to Latin America as economic advisors). These policies – with some differences in the macroeconomic measures implemented during this time – ruled the Chilean socio-economic and political environment during Pinochet’s 16-year rule until March 1990.

The implementation of neoliberal policies led to a series of negative socioeconomic consequences, including increased poverty, unemployment, and deterioration in income distribution. The first round of the reforms, during 1974-1983, was characterised by mass unemployment, purchasing power losses, extreme

inequalities in income distribution, and severe socio-economic damage (Wittelsbürger and von Hoff 2004). In the following period, 1985-1997, called the ‘golden’ or ‘boom’ period, the Chilean economy experienced a 7.1% GDP growth and a doubling of GDP per capita (de Gregorio 2004).¹ As discontent with the socioeconomic condition increased, the Pinochet government was forced to revise some of its strategies and proceeded to the reconstitution of some social movements that had been previously dismantled, such as the labour unions. With regards to economic measures, the government was still biased in favour of upper-income sectors and various business interests, while a tough position was maintained against labour organisations. Consequently, the economic policies adopted led to a further deterioration in income distribution and increased poverty (Ffrench-Davis 2005).

In order to address some of the social consequences of its economic programme, the Pinochet regime implemented measures of social assistance aimed at addressing only the basic needs of the poorest parts of the population, those who are traditionally excluded from benefits or who are unable to participate in the market. These measures, however, did not include any investments in human capital or capacity building for the poor to generate income, since according to the Chicago Boys’ philosophy, poverty was the result of rigidities in the social structure and market distortions. The goal was to identify those groups living in extreme poverty and provide them with the goods and services to maintain their standard of living, without trying to solve the problem (CEME 2010).

On the other hand, while these policies increased the provision of basic services to society’s poorest, they reduced public social assistance to the rest of the population, including the middle and working classes. As a result, many Chileans regarded these

programmes as an attempt to dismantle the social security system, which had been substantially expanded during the governments of Eduardo Frei (1964-1970) and Salvador Allende (1970-1973) (CEME 2010). Income inequality was at its lowest during the 1958-1973 period but increased significantly during 1974-1990 (Larrañaga 2001). The same happened with poverty: from an estimated poverty rate of about 20% in 1970 to 45.1% in 1987 (Ffrench-Davis 2014) (see Table 1).

Insert Table 1 about here

The democratic governments that succeeded the dictatorship sought to reverse the regressive trends in the Chilean society. After the end of the Pinochet regime in 1990, the following governments continued largely with the same neoliberal economic model, albeit with a more social focus: they increased social spending with the aim of reducing poverty and inequality, decreasing unemployment, and promoting macroeconomic stability. The result was an increase in economic growth and improvement in the standard of living of the middle class and the poorest (CEME, 2010). Thus, the measures adopted by the post-Pinochet governments managed to reduce poverty significantly; poverty and extreme poverty dropped from 29.1% in 2006 to 11.7% in 2015 (Ministry of Social Development 2016).

However, redistributive policies were less effective; despite the recent socioeconomic improvements that the country has experienced, Chile is still one of the worst countries in terms of income inequality, with a GINI coefficient of 0.495 in 2015 (Ministry of Social Development 2016). A study by López, Figueroa and Gutiérrez (2013) showed that in 2010 the 1% richest segment of the population accumulated almost 31% of the country's total income. Other studies have also underlined the

highly unequal access to good quality health care (Núñez and Chi 2013; Paraje and Vásquez 2012) and education (Matear 2007). One of the main reasons behind this persisting high inequality is that key sectors of the economy – such as banking, manufacturing, retail trade, private pension companies (AFPs), private health providers (ISAPREs), and pharmacies – are currently concentrated in the hands of few powerful families, as a result of the vast privatisation process that took place during the Pinochet regime. This leads to super-normal profits that in turn contribute to income inequality (Solimano 2009).

Neoliberalism and the Chilean health system

The construction of a neoliberal health system in Chile

The first neoliberal policies in the health system were applied in Chile during Pinochet's military government, responding to the new political and economic order that began to prevail in the country (Reichard 1996). Pinochet's first action was the removal of the National Health Service, which was in operation since 1952, and provided public health care for the entire population. This was to be accomplished through suspending the gratuity of services, and abandoning the concept of the socialist welfare state by turning Chile into a free market state (Ffrench-Davis 2005).

Decentralisation was implemented through several initiatives: the division of the National Health Service in Regional Services, municipalisation of primary health centres, and the creation of the National Health Fund (FONASA, from its initials in Spanish), which marks the separation of health care from resource management (Reichard 1996). The two major milestones of privatisation were the creation of Pension Fund Administrators (AFPs, from their initials in Spanish) in 1980 and private health insurance institutions (ISAPREs, from their initials in Spanish) in 1981. The separation of the health system in Chile in 1981 into mainly FONASA and ISAPREs

constituted a “...*regressive form of targeting and it helped to deepen the crisis in the public health system*” (Ffrench-Davis 2005: 202).

Between 1974 and 1989, the goal of reducing the role of the state in the health system was partly accomplished: fiscal contributions dropped from 68% to 35%, compulsory health insurance contributions increased from 16% to 45%, while the participation of the private health system –with regard to both resource management and service provision – increased to reach half of services in the health system by 1989 (Labra 2002). However, the complete transformation of the state system to a free market system in health was never accomplished.

Post-1990, democratic governments were faced with a series of problems regarding public health services, including a major deterioration in the public infrastructure, and inefficient management and poor coordination between regional health services and municipal authorities (Annick 2002). Working conditions and salaries had deteriorated, as a result of the deregulation and market liberalisation, leading to an increased informalisation of labour, introduced during Pinochet’s government. Especially hard-hit with regards to the quantity and quality of health care were rural areas and poor urban districts, a fact that led to an increase in regional inequality (Sanhueza and Ruiz-Tagle 2002). The informalisation of the labour market has also had a disproportionate impact on women due to a combination of lower incomes than men, and extra caring and other domestic responsibilities (Gideon 2007).

Taking into consideration the dire situation of health care services, a number of reforms in the health system were undertaken; however, the basic structure of health organisation, financing, and service provision was maintained, as highlighted by Trumper and Phillips (1997). In 2005, a comprehensive health reform took place in Chile with the goal of increasing equity in health access, financing, and service

provision. The problems that the reform aimed to address included deficits in benefits coverage in the public health system, and deficits in the protection, transparency, and high costs of the private system.

Some of the measures undertaken to address these issues included: a) strengthening and extension of the health social protection (especially for the most vulnerable groups), b) the establishment of explicit guarantees for people in a group of currently eighty prioritised pathologies (AUGE-GES programme) independent of their ability to pay for health services and treatment, c) new models for the attention and management in health, d) introduction of a number of universal benefits and programmes for health prevention and promotion (such as, National Programme for Complementary Nutrition, Health Programme for Older People, School Accidents Insurance), and e) introduction of non-contributory benefits for medical assistance of the vulnerable population (including immigrants, disabled people or people suffering from extreme poverty) (Bastias et al. 2008; Bitran, Escobar and Gassibe 2010). Public spending on health as a total of GDP also increased from 1.6% in 1990 to 3.9% in 2014 (Benavides, Castro and Jones 2013; World Bank 2016). While these reforms addressed some of the legacies of the neoliberal reforms of the Pinochet regime (Barrientos 2002), inequalities in health care persist.

The health system as a topos of structural disadvantage

Chile's health indicators are among the best in the region and are similar to those of highly industrialised countries (Bitrán, Escobar and Gassibe 2010). Life expectancy at birth is 80 years of age, maternal mortality has declined significantly, and utilisation of health services has greatly improved. Health indicators for children are also good,

particularly regarding immunisation rates and under-five mortality rates (World Health Organisation 2015a).

However, while Chile shows great improvements concerning health indicators, the country suffers from inequalities in access to health care, insufficient protection before health risks (both financial protection and access to timely attention), problems of ‘responsiveness’ (treatment, autonomy, financial justice), and cost scaling because of aging, technology, and inefficiencies (Homedes and Ugalde 2005; Rojas 2011). The current Chilean health system is a two-tier system, combining mainly public (FONASA) and private (ISAPREs) insurance, with the state having a steering role, and financing stemming mainly from the state, and taxes of workers and companies. FONASA covers more than two thirds of the population, including those officially certified as ‘indigent’ or without an income, who are fully subsidised; about 18% of higher-income Chileans are covered by ISAPREs (see Figure 1).

Insert Figure 1 about here

Unlike in other countries with dual health care system where private health care is optional and complementary to the public one, in Chile private health insurance companies (ISAPREs) are an alternative to FONASA (that is, people have to choose one or the other). This has led to stratification of access to health: a) the higher socio-economic classes are affiliated with one of the thirteen available ISAPREs, and can opt for different premiums to improve their health plan; b) the middle-income classes usually opt for public health insurance (FONASA), with variable co-payments depending on their income; and c) the lower socioeconomic classes and the poor access

FONASA for free or paying an amount depending on their income (Labra 2002; Núñez and Chi 2013).

The contract premium for ISAPREs is determined by sex, age, and risk, a fact that often excludes women of reproductive age, the elderly or the young, creating a structural disadvantage for these parts of the population. As a result, ISAPREs mostly attract the affluent, male, young, and urban population. In 2015, only 2.9% of the poorest quintile were members of ISAPREs; the percentage reached 38.2% for the richest quintile (Ministry of Social Development 2016). Adult women of reproductive age may pay up to four times more than men, and the proportion of people over 60 years of age affiliated with ISAPREs drops dramatically since they face premiums of up to eight times as much as those of young male adults (Unger et al. 2008).

This is an extreme form of responsabilisation: people are not only asked to be responsible for their own health but they are also penalised for who they are, further excluding them from the health care system. This has a dramatic effect on the accessibility of the healthcare system; a cross-sectional analysis of population-level data revealed that people with disabilities have worse access to healthcare (Rotarou and Sakellariou 2017). This may be linked to the fact that only 3.4% of people with disabilities are affiliated with an ISAPRE (on account of higher premiums due to their disability), compared to 10.5% of people without a disability. This is problematic because irrespective of disability status and despite universal coverage, people are more likely to face difficulties in accessing health care if they are affiliated with the public health provider (Rotarou and Sakellariou 2017).

It must be pointed out that several of the ISAPREs are controlled by subsidiaries of multinational companies based outside Chile, which according to Gideon (2007: 80), “...raises important questions over the ability of the state to regulate ISAPREs

effectively”. Indeed, while the privatisation of more health care services requires a greater vigilance of the private sector from the part of the government, weakened governments – under the neoliberal policies of promoting privatisation and cutting back on the capacity of the public sector – are less able to protect their members from abuses by third-party institutions (Chapman 2014), in our case, abuses by the ISAPREs and the multinational companies that own them.

Ultimately, the beneficiaries of the neoliberal health care reforms in Chile have been, primarily, the transnational corporations, such as insurance firms that manage the ISAPREs (Homedes and Ugalde 2005). Despite the slowing down of the Chilean economy for the last few years and the poor performance of other sectors, ISAPREs’ profits reached about USD 60 millions in 2015; their profits for the last decade surpassed USD 860 millions (Teletrece-T13 2016). Adding to that the revelations of significant political donations in the last ten years from powerful business entities / conglomerates (from the banking sector, industry, pension funds, and health funds), the powerful grip and influence of the ISAPREs on the Chilean economic, social, and political sphere is evident (Matamala 2016).

Recent health reforms – and particularly, the 2005 comprehensive reforms – have tried to reduce existing inequalities in the Chilean health care system. The impact of these reforms can be assessed on the basis of equity, in terms of finance, access, and health status:

- *Financial equity*: In 2013, per capita health expenditure of an ISAPRE affiliate was 50% more than that of a FONASA affiliate, which makes the ISAPRE expenditure closer to the per capita expenditure in countries such as Spain and the United Kingdom (Vega 2014); by contrast, the FONASA expenditure is as low as that of the average for Latin American countries (Cid 2011). This is due to the fact that ISAPREs, due to ex-

ante (for example, cream-skimming) and ex-post (for instance, adjustment for sex, age, or health conditions) risk selection keep expected risks / costs below the average. It is also because ISAPREs affiliates have a greater financial ability to buy high premiums and are in general better health than FONASA users, and therefore, have a lower risk / cost (Paraje and Vásquez 2012).

▪ *Equity of access to care:* Recent studies have found that inequities in utilisation rates benefit the most well-off, and that the poor use fewer health care services than they actually need (Núñez and Chi 2013; Paraje and Vásquez 2012). Research has also shown that the frequency of surgeries and laboratory tests was positively correlated with income (Unger et al. 2008). Gideon (2007) stresses the gendered nature of exclusion from health care services and its links to the informalisation of labour and the extra domestic labour expectations for women. While the AUGE-GES² system developed in the 2005 reforms went some way to providing equal care to men and women by removing the expectation of a female dependent, Dannreuther and Gideon (2008) argue that AUGE-GES does not address the broader structural issues that render women more vulnerable to ill health and with reduced likelihood to access health care. Vásquez, Paraje and Estay (2013) found pro-rich inequity for specialised, dental, general practitioners and physician visits. Frenz et al. (2013), on the other hand, found that with the introduction of the AUGE-GES system, access to health care in Chile has become more equitable and responsive to the needs of the patients; they do underline, however, that equity issues still remain regarding quality of care, barriers to health system, and differential access for health problems that are not covered by AUGE-GES. Valdebenito, Kalpiriri and Martin (2009) stress the fact that while the AUGE-GES system has increased utilisation, its benefits are not shared out equally, and several people are not informed of their rights under this system. Paraje and Vásquez

(2012) mention extra barriers to equitable access to health care, including insufficient medical human resources, financial barriers, and capacity constraints.

- *Equity of health status:* Over the last few decades, life expectancy in Chile has increased significantly, while various health indicators (such as infant and maternal mortality) have also improved. This has been the outcome of better living conditions resulting from socioeconomic development, maternal and child protection programmes carried out by the public sector, and strong policies in preventive care (Missoni and Solimano 2010; Unger et al. 2008). Still, the potential productive years of life lost in the poorest quintiles in Santiago are more than in the richest quintile (Unger et al. 2008). Overall, morbidity and mortality vary depending on socioeconomic status and place of residence, indicating the existing spatial socioeconomic segregation, and the ineffectiveness of various health programmes to benefit disadvantaged groups (Missoni and Solimano 2010).

Concluding remarks

Neoliberalism focuses on the notions of privatisation, liberalisation, deregulation, and minimal state interference in the economy. In the neoliberal discourse, people become consumers. Since some products are more desirable than others, people are expected to pay higher for the products they most need, such as health. The power (purchase, but also symbolic) of patient-consumers then, depends on the monetary and social capital at their disposal; in other words, people must know what they need, where to get it from, and be able to pay for it.

The neoliberal economic model employed in Chile focussed on the delivery of public goods – such as education, infrastructure, and health – through concessions to private companies, whose final aim is economic profitability over social benefit. The

existence of a dual health system – public and private – has led to insufficient protection against health risks, as well as differentiation and stratification of access to health, transforming health into a marketable need rather than a right to which everybody is entitled. Furthermore, the close alignment of Chilean social policies with neoliberalism has produced several effects which impact upon people's access to health care: these include the marketisation of health care, but also an increasingly powerful discourse of responsabilisation. As Manderson and Warren (2016) have demonstrated, this discourse is often acontextual, treating people as entirely autonomous units, with equal amounts of agency to mobilise resources and effect change in their lives. This is problematic for a variety of reasons. First, the presence of income inequality – which, in the case of Chile, is very high – forms a structural disadvantage, which can lead to reduced economic and social capital, often resulting in further ill health. Second, the local environments where people live, work, fall ill, and seek health services, play a major role in experiences of health and illness and in the ways these are negotiated within people's lives.

It is important to bear in mind that improving equity in health care access and utilisation is a matter of human rights. According to the World Health Organisation (2015b), all people should have both *freedoms* to control their health and bodies without interference, and *entitlements* to access health care protection that is timely, acceptable, affordable, and of appropriate quality. A human-rights approach to health stands in contrast to the discourse of responsabilisation and marketisation offered by neoliberalism, since it seeks to address inequalities and discriminatory practices that result in inequitable health outcomes. This is particularly relevant in the current context of efforts to restructure health care systems towards a more efficient and cost-reducing neoliberal model that moves away from the human-rights approach to health: examples

include the attempts of the current US administration to dismantle the Patient Protection and Affordable Care Act – widely known as Obamacare –, and the health reforms imposed on crisis-stricken Greece by the IMF and the Eurozone. These reforms include austerity measures, restrictions on access and privatisation schemes, and deregulation of private health services, which have only led to serious, negative consequences on population health and health care services (see for example Economou et al. 2014; Kentikelenis et al. 2004).

While Chile has made important steps towards achieving equitable access to health care services – especially with the introduction of the AUGE-GES system that greatly increased the utilisation of such services – the legacy of the neoliberal policies implemented in the health sector is still present. The existence of the dual health system has led to pro-rich inequities and differential access by gender, income, and age-group. It is, therefore, imperative that the Chilean state takes into account this reality in order to monitor and evaluate efforts aimed at tracking progress and identifying critical challenges, while at the same time, actively intervening in health care regulation, financing and service provision so as to bring all Chileans closer to the goal of equitable, timely, and good-quality health care services.

Endnotes

¹ During the second period of reforms (1982-1989) of the Pinochet government, the economy experienced a vigorous recovery, especially during the end of this period. Nevertheless, if the 1982-1983 recession is taken into account, the GDP growth for the entire 16 years of the military government was just 2.9% (Ffrench-Davis 2014).

²AUGE-GES is a mechanism developed with the aim to ensure the timely treatment of all Chileans suffering from a group of eighty pathologies, at a reasonable cost and with a quality guarantee (for more information, please see the website of the Ministry of Health of Chile: <http://www.supersalud.gob.cl/difusion/572/w3-propertyvalue-3130.html>)

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Table 1¹: Various indicators for Chile; 1960-2014

Variable	1960-1970	Allende 1971-1973	Pinochet 1974-1989	1990-1999	2000-2009	2013	2014
GDP growth (%)	3.9	1.2	2.9	5.1	3.7	4.3	1.9
Inflation rate (%)	26.5	293.8	79.9	7.0	3.4	1.8	4.4
Unemployment rate (%)	5.6	4.7	18.1	8.7	9.7	6.0	6.3
Poverty rate (%) ²	-	-	45.1	28.8	16.0	14.4	-
GINI index	0.489	0.466	0.547	0.523	0.521	0.509	-
Income distribution (Q5/Q1)	12.9	12.8	17.7	15.7	14.9	-	-

¹Own elaboration from Banco Central de Chile 2015; Ffrench-Davis 2014; Ministry of Social Development 2014; and University of Chile 2015.

²Previous studies have indicated that poverty in 1970 was 17% (Fazio 1996) or 20% (Ffrench-Davis 2014) or 23% (Sepúlveda 2008), and although the poverty rate might have been underestimated, it is lower than in the Pinochet period. According to Sepúlveda (2008), it dropped to 12% by the end of Allende's government. Poverty for the period 1974-1989 is the 1987 figure.

Figure legends and figure notes

Figure 1

Affiliates to public and private insurance and evolution of per capita health expenditure, US\$, 1990-2014

Figure 1 notes

Own elaboration from FONASA (2015) and OECD database (2016)

Note 1: The Armed Forces who have their own insurance, and people without insurance or who pay out-of-pocket are included in the category of “other”.

Note 2: ISAPREs affiliates reached 26% of the population in 1997 and declined to 16% in 2005. This decrease was due to improved performance of FONASA, unemployment caused by the 1990s Asian crisis, and the rising costs of private health plans (Unger et al. 2008).